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Abstract

Rural communities throughout the United States lack sufficient access to quality health care services. Scholars suggest that these deficiencies persist despite a national consensus regarding the need for improved medical care; although bipartisan coalitions in the US House and Senate propose and support rural health care policy initiatives, Congress rarely enacts effective legislation. Existing research focuses on deficiency solutions and policy proposals, but few studies address the politics of rural health care reform. This study attempts to fill this gap. It examines legislative inertia through an analysis of two cases: the Emergency Health Personnel Act (EHPA) of 1970 and Health Care Access and Rural Equity (H-CARE) Act of 2007. The former legislation was successful; the latter failed. An analysis of these proposals finds that a combination of factors – including executive leadership, urban-centrism, and diverse policy proposals – contribute to successful or failed legislation.

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Hillbilly Health Care: The Politics of Rural Health Care Reform

Casey Yamashita

Rural communities throughout the United States lack sufficient access to quality health care services. Scholars suggest that these deficiencies persist despite a national consensus regarding the need for improved medical care; although bipartisan coalitions in the US House and Senate propose and support rural health care policy initiatives, Congress rarely enacts effective legislation. Existing research focuses on deficiency solutions and policy proposals, but few studies address the politics of rural health care reform. This study attempts to fill this gap. It examines legislative inertia through an analysis of two cases: the Emergency Health Personnel Act (EHPA) of 1970 and Health Care Access and Rural Equity (H-CARE) Act of 2007. The former legislation was successful; the latter failed. An analysis of these proposals finds that a combination of factors – including executive leadership, urban-centrism, and diverse policy proposals – contribute to successful or failed legislation.

Introduction

During their free time, M. Denise Williams and Margaret Hobson moonlight as matchmakers. These physicians – employed at the Southern Albemarle Family Practice in Esmont, Virginia – desperately want their new colleague, Dr. Sarah Carricaburu, to stay in Esmont. The National Health Service Corps – a federal organization that promises scholarships and loan repayment to physicians willing to spend three years in rural areas – assigned Carricaburu to Esmont; Carricaburu intends to leave when her term-of-service ends.¹ Williams and Hobson hope that Carricaburu elects to remain in Esmont and pay close attention to her requests and complaints: Williams and Hobson helped Carricaburu move to Esmont from Washington, DC; they upgraded the clinic’s computer and internet services; and, when Carricaburu bemoaned the lack of “dateable” men in Esmont, they set her up on a series of dates.²

Williams and Hobson are motivated by the area’s conspicuous and persistent dearth of health care providers. For over two decades, they served as Esmont’s only physicians.³ Although they treated about 40 patients per day, worked more than 60 hours per week, and made numerous house calls, Williams and Hobson struggled to meet the growing medical needs of their rural community; they often turned away, or triaged, patients.⁴ As a result, basic medical conditions went untreated: simple infections became debilitating illnesses; diabetes often resulted in amputations; and various forms of cancer went undiagnosed.⁵ Williams and Hobson lacked the resources and human power to address this problem and thus welcomed Carricaburu to their clinic. They worry that health care availability will decrease when Carricaburu leaves – and want

¹ Fears, Darryl, “Renewed Effort to Lure Doctors to Rural Areas Faces Obstacles,” *The Washington Post*, 9 August 2010.

² Fears, “Renewed Effort.”

³ Fears, “Renewed Effort.”

⁴ Fears, “Renewed Effort.”

⁵ Fears, “Renewed Effort.”

Carricaburu to stay – but also acknowledge that they are lucky: many rural communities do not receive NHSC physicians and suffer greater deficiencies.

Rural communities throughout the United States face persistent health care shortages. These areas – commonly defined as non-metropolitan communities inhabited by fewer than 50,000 individuals – lack sufficient numbers of health care providers and adequate facilities.⁶ Although Congress and various state governments have attempted to address this shortage since the late 1940's, the Office of Rural Health Policy (ORHP) estimates that deficiencies have largely remained constant throughout the last half-century.⁷ Rural health care policy experts argue that this may be attributed to ineffective federal leadership, and insufficient funding, for non-metropolitan health care initiatives;⁸ they suggest that Congress is often unwilling to enact effective rural health care legislation. This inertia persists despite a general bipartisan consensus: rural communities need improved access to care. Existing academic literature proposes numerous solutions for rural health deficiencies, but it fails to address the reasons for political inaction. This study thus attempts to identify the factors informing inertia.

The following examines rural health care policies and proposes a hypothesis for both success and failure. It is divided into three parts: the first examines relevant academic conversations and ideological frameworks concerning rural health care legislation; the second proposes and details a methodology – based on a most similar-systems case study design – for the study of rural health care legislative inertia; the third explains the results of the study.

⁶ Ricketts, Thomas C., “Workforce Issues in Rural Areas: A Focus on Policy Equity,” *American Journal of Public Health* 95, no. 1 (2006): 44.

⁷ Ricketts, “Workforce Issues,” 45.

⁸ Cordes, Sam M., “Come On In, the Water's Just Fine,” *Academic Medicine: Journal of the Association of American Medical Colleges* 65, no. 12 (1990): 51-59; Foster, Stuart A., and Wilpen L. Gorr. “Federal Health Care Policy and the Geographic Diffusion of Physicians: A Macro-scale Analysis.” *Policy Sciences* 25, no. 1 (1992): 117-134.

Research centers around a central question: what factors contribute to successful and failed rural health care policy initiatives?

Literature Review

An understanding of the literature regarding agenda-setting and policy formation, New Federalism, urban-centrism, competing social and economic theories of rural health care reform, and power is fundamental to any study of rural health care legislative inertia. John Kingdon's theory of policy formation serves as the primary conceptual framework for this study; Kingdon argues that any area of public policy consists of three "streams": the political, problem, and policy streams.⁹ These streams sometimes "couple": an appropriate combination of these environmental factors and specific policy alternatives creates conditions favorable to policy consideration and enactment.¹⁰ Policy windows – opportunities for a specific issue to gain prominence on a federal agenda – simultaneously open; the coupled and coherent streams then flow through the open policy window.¹¹ New Federalism, urban-centrism and competing social and economic theories of reform are important in this context because they comprise the political, problem, and policy windows. Power, and the various theories of power relationships, explain the concepts underlying legislative inertia. The following discusses the prominent literature available within each of the aforementioned academic conversations.

The Political Stream: New Federalism

Federalism – the varying role and jurisdiction of the federal government – plays an important role in shaping rural policy. Rural health care scholars often detail the recent history of US federalism, examine the current brand of American federalism, and then explain why this

⁹ Kingdon, John W., *Agendas, Alternatives, and Public Policies*. (New York: Addison-Wesley Educational Publishers Inc., 2003), 201.

¹⁰ Kingdon, *Agendas*, 173.

¹¹ Kingdon, *Agendas*, 166.

model inhibits rural health care reform. Nathan¹² and Roberts¹³ both adopt this model in their studies of rural statistics. They each suggest that federalism is cyclical¹⁴ and tied to the national political atmosphere:¹⁵ periods of liberal political dominance create strong federal systems; conservative eras engender a more decentralized federal government that espouses decreased spending and the shifting of responsibilities to state and local governments.¹⁶ Nathan explains that rural health care policies enacted during liberal periods are primarily funded and overseen by the federal government; state governments sometimes enact modified versions of successful federal policies.¹⁷ During conservative periods, state governments function as the primary innovators, and the federal government adopts popular and successful policies.¹⁸ Nathan,¹⁹ Roberts,²⁰ Hudnall Stamm,²¹ Thompson,²² Morgan,²³ and Ricketts,²⁴ agree that the current mode of federalism is conservative-centric. Roberts explains the current model of federal rural health care delivery: under this “New Federalism” – an ideology that gained prominence during the 1970s and 1980s – the federal government enacts legislation creating rural clinics or supporting programs that draw clinicians to rural areas, but it cedes all other responsibilities to the states.²⁵ Rural health care scholars, including these authors, often argue that this ideology is detrimental

¹² Nathan, Richard P., “Federalism and Health Policy,” *Health Affairs* 24, no. 6 (2005), 146.

¹³ Roberts, Jane F., “The Impact of the New Federalism,” *Bulletin of the New York Academy of Medicine* 62, no. 20 (1986), 108.

¹⁴ Nathan, “Federalism and Health Policy,” 147.

¹⁵ Roberts, “Impact of New Federalism,” 110.

¹⁶ Nathan, “Federalism and Health Policy,” 147.

¹⁷ Nathan, “Federalism and Health Policy,” 148.

¹⁸ Ibid.

¹⁹ Nathan, “Federalism and Health Policy,” 150.

²⁰ Roberts, “The Impact of New Federalism,” 109.

²¹ Hudnall Stamm, B. eds., *Rural Behavioral Health Care*, Washington, D.C.: American Psychological Association, 2003.

²² Thompson, Frank J., “New Federalism and Health Care Policy: States and the Old Questions,” *Journal of Health Politics, Policy, and Law* 11, no. 4 (1986): 647-669.

²³ Morgan, Lynn M., “Dependency Theory in the Political Economy of Health: An Anthropological Critique,” *Medical Anthropology Quarterly* 1, no. 2 (1987), 140.

²⁴ Ricketts, Thomas C., “Workforce Issues in Rural Areas: A Focus on Policy Equity,” *American Journal of Public Health* 95, no. 1 (2006), 42.

²⁵ Roberts, “The Impact of New Federalism,” 110.

to the development and passage of effective rural health care programs – programs that sufficiently and efficiently address health care deficiencies.

Studies and policy analyses of federal rural health care policies demonstrate a unifying theme: they argue that the federal government should adopt a greater role in addressing rural health care shortages. Scholars acknowledge that New Federalism is the nation's prevailing framework, but they also assert that the federal government must devote more resources to rural systems. Nathan,²⁶ Roberts,²⁷ and Thompson²⁸ establish their argument for improved federal involvement by employing statistical analyses that demonstrate progressively declining rural health care coverage. Thompson analyzes both regional health care and governmental efficiency statistics – the proponents of New Federalism often argue that improvements in state efficiency justify decreased services – and observes a dramatic reduction in services available to poor and underserved populations.²⁹ He suggests that gains in efficiency are more than offset by health care coverage reduction.³⁰ Ormond, Wallin, and Goldenson³¹ conduct numerous case studies in Alabama, Mississippi, Minnesota, Texas, and Washington; they compare rural clinician availability – and the nature of available services – to the national average.³² They use these studies to emphasize health care disparities and argue for more federal oversight. Morgan's piece focuses on the political economy of health care and the need for an interdisciplinary approach to health care studies, but she also alludes to the need for the federal government to expand rural health care programs.³³ Hudnall Stamm³⁴ and Ricketts³⁵ argue that rural health care programs

²⁶ Nathan, "Federalism and Health Policy," 152.

²⁷ Roberts, "The Impact of New Federalism," 112.

²⁸ Thompson, "States and Old Questions," 658.

²⁹ Thompson, "States and Old Questions," 660.

³⁰ Ibid.

³¹ Ormond, Barbara A., Susan Wallin, and Susan M. Goldenson., *Supporting the Rural Health care Safety Net*. (Washington, D.C.: The Urban Institute, 2000), 4.

³² Ormond, Wallin, and Goldenson, *Safety Net*, 15.

³³ Morgan, "Dependency Theory," 144.

³⁴ Hudnall Stamm, *Rural Behavioral Health Care*, 8.

immensely improve rural communities: in many rural communities, health care services form the backbone of the local economy and provide important opportunities for leadership.

Each of these authors explicitly or implicitly criticizes New Federalism as a poor framework that detrimentally affects rural health care policies. Some differences in opinion are evident in the varying degrees to which they believe New Federalism is detrimental: Ricketts and Ormond, Wallin, and Goldenson believe that diversity among rural communities allows some areas to enjoy greater coverage than others – a kind of rural health care natural selection. However, Hudnall Stamm, Nathan, Roberts, Thompson, and Morgan treat New Federalism as a comprehensively detrimental ideology. Regardless of the degree to which New Federalism impacts rural communities, scholars agree that this political philosophy plays an important role in rural health care policy development. It thus comprises the “political” stream in Kingdon’s model of policy development; it may inhibit policy formation and prevent the opening of a specific window: the political window.

The Problem Stream: Urban-centrism

Another window – the “problem window” – also impacts agenda-setting. Relevant literature suggests that urban-centrism – defined as a collection of stereotypes, misconceptions, and assumptions that negatively impact US rural policy, including a belief in the consistent health, robust environmental conditions, and economic vitality of rural people – partially comprises the problem stream; it prevents the opening of the problem window. Hudnall Stamm,³⁶ Castle,³⁷ Cordes,³⁸ and Bonnen³⁹ suggest that urban and suburban populations believe

³⁵ Ricketts, “Workforce Issues,” 42.

³⁶ Hudnall Stamm, *Rural Behavioral Health Care*, 12.

³⁷ Castle, Emery N., “A Conceptual Framework for the Study of Rural Places.” *American Journal of Agricultural Economics* 80 (1998), 626.

³⁸ Cordes, Sam M. “Come On In,” 54.

³⁹ Bonnen, James T., “Why is There No Coherent U.S. Rural Policy?,” *Policy Studies Journal* 20, no. 2 (1992), 193.

in the exaggerated vitality, homogeneity, and endurance of rural communities. (The term urban-centrism may be attributed to Hudnall Stamm,⁴⁰ but Castle, Cordes, and Bonnen argue that congruent assumptions and biases afflict rural health care policies.) Stamm argues that the inhabitants of metropolitan communities typically believe that their rural counterparts are naturally healthier and able to endure greater difficulties; therefore, rural communities do not need more health care services.⁴¹ Castle⁴² and Cordes⁴³ both point out that most of the legislation concerning rural communities are considered, modified and enacted by urban and suburban lawmakers – individuals most likely to adopt urban-centric political stances. They explain that this phenomenon occurs because committee chairmen – in the US House and Senate – and Congressional leaders often hail from urban and suburban areas.⁴⁴ Ricketts, Konrad, and Wagner⁴⁵ expand on this idea and, through a statistical analysis of federal rural allocations, suggest that ethnically homogeneous rural districts receive more funding than heterogeneous areas.

James Bonnen attributes urban-centrism to a powerful agribusiness lobby⁴⁶ and the mass media.⁴⁷ These groups, he writes, perpetuate a powerful and fallacious stereotype: rural economies are centered around agriculture.⁴⁸ Cordes⁴⁹ and Bonnen⁵⁰ both detail the history of urban-centrism and explain that American farms served as the backbone of rural systems prior to the 1950's. A gradual market shift away from small family farms – to larger farms and other,

⁴⁰ Hudnall Stamm, *Rural Behavioral Health Care*, 12.

⁴¹ Hudnall Stamm, *Rural Behavioral Health Care*, 15.

⁴² Castle, "A Conceptual Framework," 630.

⁴³ Cordes, "Come on In," 58.

⁴⁴ Castle, "A Conceptual Framework," 631; Cordes, "Come on In," 58.

⁴⁵ Ricketts, Thomas C., Thomas R. Konrad, and Edward H. Wagner., "An Evaluation of Subsidized Rural Primary Care Programs: The Environmental Contexts," *American Journal of Public Health* 73, no. 4 (1983), 412.

⁴⁶ Bonnen, "No Coherent Rural Policy," 192.

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Cordes, Sam M., "The Changing Rural Environment and the Relationship Between Health Services and Rural Development," *Health Services Research* 23, no. 6 (1989), 775.

⁵⁰ Bonnen, "No Coherent Rural Policy," 192.

non-natural resource industries – created rural areas that are no longer dependent on farming.

⁵¹The agribusiness lobby, however, continues to emphasize the importance of the family farm, to maintain federal agriculture subsidies; the mass media perpetuate this stereotype. This has two consequences: it reinforces an urban and suburban belief in the vitality of rural peoples, since Americans generally associate farmers with physical and mental strength; and it creates a political climate in which there is no delineation between agricultural and rural legislation.⁵²

Bonnen argues that legislators often acknowledge that agricultural subsidies are the best way to aid rural communities; lawmakers believe that these funds will reach a large percentage of the population.⁵³ They thus ignore other areas of concern – including rural health care – and are unlikely to revisit rural legislation after enacting agricultural subsidies. Bonnen's theories are still relevant; Cordes explains that rural populations are progressively less dependent on agriculture, and the agribusiness lobby continues to maintain an important presence in Washington.⁵⁴

Rural health care scholars seem to agree that urban-centrism negatively impacts legislation: it prevents legislators from realizing the urgency and need associated with rural health care deficiencies. This collection of stereotypes and misconceptions comprises the “problem stream.” Rural health care policies rarely become prominent parts of the national agenda because legislators may believe that the status-quo is not a problem. This study focuses both on this factor – it comprises the problem stream – and the problem stream's interactions with other streams – including the policy stream.

⁵¹ Cordes, “Changing Rural Environment,” 776.

⁵² Bonnen, “No Coherent Rural Policy,” 193.

⁵³ Bonnen, “No Coherent Rural Policy,” 197.

⁵⁴ Cordes, “Changing Rural Environment,” 776.

The Policy Stream: Competing Social and Economic Theories of Reform

Rural health care scholars advocate two diverse modes of reform. Foster and Gorr,⁵⁵ Wellever and Casey,⁵⁶ and Cordes⁵⁷ believe that the federal government should address rural health care deficiencies through economic strategies. They argue that health care shortages stem from a lack of clinicians – primary care physicians, specialists, dentists, physical therapists, and other health care providers. Foster and Gorr explain that this represents market failure: rationally-minded clinicians should diffuse from areas of low demand and high competition to areas of high demand and low competition.⁵⁸ The federal government should thus rectify market failure by offering financial incentives to health care workers willing to relocate to underserved areas. As evidence, Foster and Gorr, Wellever and Casey, and Cordes cite access-to-care statistics associated with the National Health Service Corps (NHSC). This institution – established by the Emergency Health Personnel Act of 1970 – offers scholarships and loan repayment to physicians willing to practice in underserved rural and urban areas. Statistics compiled over the last four decades indicate increased health care services in areas that qualify for NHSC physician assignment, and physicians report an overall satisfaction with the program.⁵⁹ Economic theorists thus maintain that financial incentives are the best solution for rural health care deficiencies.

Other rural health care scholars espouse a more comprehensive, community-based approach to reform. Ormond, Wallin, and Goldenson believe that health care networks – in which various health care professionals work in clinics scattered throughout rural districts – adequately addresses deficiencies.⁶⁰ These networks provide support services necessary for

⁵⁵ Foster and Gorr, “Geographic Diffusion,” 124.

⁵⁶ Casey, Michelle N., and Anthony Wellever., “Rural Health Network Development: Public Policy Issues and State Development,” *Journal of Health Politics, Policy & Law* 22, no. 1 (1997), 40.

⁵⁷ Cordes, “Come On In,” 56.

⁵⁸ Foster and Gorr, “Geographic Diffusion,” 123.

⁵⁹ Cordes, “Come On In,” 58.

⁶⁰ Ormond, Wallin, and Goldenson, *Rural Health care Safety Net*, 12.

comprehensive patient care: secondary health care providers - including physical therapists, occupational therapists, and other specialists⁶¹ – and access to medical facilities like clinical laboratories.⁶² Ricketts, Konrad and Wagner concur: programs like the National Health Service Corps – a federally-funded organization that promises loan repayment and scholarships to physicians willing to spend three years in underserved areas – draw physicians to rural areas, but a lack of health care support services forces these doctors to relocate.⁶³ Their study of subsidized rural health care programs suggests that the federal government should supplement financial incentives with adequate clinical support. Ricketts, in a separate study, expands on this idea: health care deficiencies do not represent market failure. Instead, physicians, in general, refrain from practicing in areas that lack adequate support services – employment in the health care field is thus unlike that of any other service industry. Pathman, Konrad and Ricketts, in a study of rural residency effectiveness, implicitly espouse comprehensive reform: rural preceptorships were established to address market failure and expose clinicians to rural settings; however, these statistics demonstrate that preceptorship programs do not significantly increase physician density in any given area.⁶⁴

The solutions proposed by economic and social theorists are not in complete contradiction – despite their glaring, fundamental differences. Economic theorists espouse a limited strategy for addressing rural health care deficiencies: they believe that increased financial incentives will bolster clinician density in rural systems. Social theorists build on this idea: the federal government should offer these incentives, but it should also establish comprehensive programs and facilities that can adequately support and sustain larger numbers of clinicians. The

⁶¹ Ormond, Wallin, and Goldenson, *Rural Health care Safety Net*, 13.

⁶² Ormond, Wallin, and Goldenson, *Rural Health care Safety Net*, 12.

⁶³ Ricketts, Thomas C., Thomas R. Konrad, and Edward H. Wagner., “An Evaluation of Subsidized Rural Primary Care Programs: The Environmental Contexts.” *American Journal of Public Health* 73, no. 4 (1983), 407.

⁶⁴ Ricketts, Konrad, and Wagner, “An Evaluation,” 408.

aforementioned authors refrain from explicitly criticizing or rejecting their theoretical “opponents.” Instead, each focuses on justifying the scale of rural health care reform. However, these discordant proposals create a discussion devoid of a clear and coherent solution. The ideas advanced by these scholars comprise the “policy stream” of the rural health care policy area, and the lack of a widely-supported solution – the lack of a coherent policy stream – hampers coupling with other streams.

Power

The dimensions of power, as well as Michel Foucault’s characterization of power, underlie rural health care legislative inertia. Robert Dahl proposes a model of power in which one measures explicit exercises of power: “*A* has power over *B* to the extent that he can get *B* to do something that *B* would not otherwise do.”⁶⁵ Dahl and his contemporaries – the pluralists, including Nelson Polsby and Raymond Wolfinger – believed that an individual’s thoughts are inseparable from his actions; they believed that one can accurately determine power relationships by observing the actions of political actors.⁶⁶ The pluralists applied this idea to political studies; they tried to identify power relationships in various communities and often concluded that power is decentralized – they were unable to identify a dominant individual or group. This is often termed the “one-dimensional” view of power, and it has important rural health care policy implications. The agribusiness lobby directly exercises power over federal government by convincing Congress of the need for increased agriculture subsidies; congressmen often decry federal agriculture spending, but the agribusiness lobby focuses its attention on agricultural, rather than rural health care or education, issues.⁶⁷

⁶⁵ Lukes, Stephen. *Power: A Radical View*. (New York: Palgrave MacMillan, 2005), 16.

⁶⁶ Lukes, *Power*, 16.

⁶⁷ Bonnen, “No Coherent Rural Policy,” 194.

The second dimension of power – espoused by Peter Bachrach and Morton Baratz – builds on the first dimension. It focuses on both decisions and non-decisions; this model argues that one must analyze the explicit political agenda and deliberations, and the items that fail to reach the agenda.⁶⁸ Non-decisions are “decisions that result in suppression or manifest challenge to the values or interests of the decision-maker.”⁶⁹ These ideas, proposals, and solutions are driven from the political mainstream and considered unacceptable. Bachrach and Baratz argue that power can be exercised directly, by accepting or rejecting policies, or indirectly, by preventing a policy from becoming part of the conversation.⁷⁰ Applications of this dimension are evident in the policy stream of rural health care reform. Specific solutions – like constructing rural hospitals in every rural district – are deemed unfavorable because they are unfeasible. These ideas are only discussed in the context of being outside the policy community mainstream.

The third-dimension of power and Michel Foucault’s theories of power are also relevant to any study of rural health care legislative inertia. The third-dimension – defined by Steven Lukes as preference-shaping and the ability of an individual or group to influence the beliefs and values that shape one’s contribution to a policy conversation – is more comprehensive than those developed by the pluralists or Bachrach and Baratz.⁷¹ Lukes integrates these theories into his model, but he emphasizes the importance of studying “latent conflict.”⁷² He criticizes his intellectual forebears as overly-simplistic; instead of only studying observable conflict, one must also identify and analyze the factors that larger factors that inform preferences.⁷³ New Federalism, and the proponents of New Federalism, exemplify this dimension: this framework,

⁶⁸ Lukes, *Power*, 20.

⁶⁹ Lukes, *Power*, 22.

⁷⁰ Ibid.

⁷¹ Lukes, *Power*, 26.

⁷² Lukes, *Power*, 29.

⁷³ Lukes, *Power*, 29.

combined with a conservative national mood, influences preferences. Legislators are likely to consider and reject specific policy alternatives because of this ideology's dominance.

Foucault's theories of power – he argues that power relationships pervade everyday life – are also relevant. Foucault argues that numerous, established systems – for example, the federal education system – function as exercises of power: they force individuals to conform to specific societal norms.⁷⁴ He suggests that power is exercised by every institution, regardless of its benign connotations. One may argue that rural health care programs enacted by the federal government – including the legislation establishing the National Health Service Corps – are exercises of power because they force physicians, clinicians or other health care workers to conform to established norms.

Methodology

Rural communities throughout the United States face persistent health care shortages. These areas lack sufficient numbers of health care providers and adequate facilities; researchers – including those mentioned in the “New Federalism” section of this study – often attribute these deficiencies to ineffective or failed federal rural health care legislative initiatives. This study attempts to understand this legislative inertia by comparing successful and failed instances of reform; positive and negative examples must be studied to provide a comprehensive understanding of the legislative process. John Kingdon's theories of policy formation served as the primary conceptual framework for analysis; research centered around a most-similar systems case study design. This approach is the most effective for comparative analysis and factor identification.

⁷⁴ Lukes, *Power*, 75.

Policy Windows

John Kingdon believes that a policy becomes part of a political agenda through a complicated and protracted process. He explains that the political, problem, and policy streams comprise any policy zeitgeist.⁷⁵ These streams continually flow and contain diverse environmental factors and policy alternatives: the political stream consists of the “national mood,”⁷⁶ “organized political forces,”⁷⁷ and key political actors; the problem stream centers around the level of urgency assigned to a specific condition or issue;⁷⁸ the policy stream consists of the various – feasible and unfeasible – solutions, alternatives, and proposals related to a specific issue.⁷⁹ An item becomes part of the political agenda, in part, when these streams successfully merge and form a feasible, actionable, and politically acceptable policy. Kingdon refers to this process as “coupling” and asserts that it is an important part of the policy formation process: “if one of the three elements is missing – if a solution is not available, a problem cannot be found, or is not sufficiently compelling, or support is not forthcoming from the political stream – then the subject’s place on the decision agenda is fleeting.”⁸⁰ Coupling is thus conducive to agenda-setting, and it helps a policy proceed through an open policy window.

Open policy windows are opportunities for policy advancement. This is a large and immensely encompassing window that opens when a smaller window – the political or problem window – opens.⁸¹ Political windows open when national political conditions – including the national mood or party controlling the executive or legislative branches – change.⁸² Problem windows open when an issue or “condition” becomes a “problem”; legislators and the general

⁷⁵ Kingdon, John W., *Agendas, Alternatives, and Public Policies*, (New York: Addison-Wesley Educational Publishers Inc., 2003), 173.

⁷⁶ Kingdon, *Agendas*, 146.

⁷⁷ Kingdon, *Agendas*, 150.

⁷⁸ Kingdon, *Agendas*, 198.

⁷⁹ Kingdon, *Agendas*, 201.

⁸⁰ Kingdon, *Agendas*, 178.

⁸¹ Kingdon, *Agendas*, 203./

⁸² Kingdon, *Agendas*, 174.

public are more likely to take action if they believe in the urgency and importance of a specific issue.⁸³ Both of these window openings indicate favorable conditions for policy proposal and enactment. The larger policy window subsequently opens,⁸⁴ and this represents an opportunity for “policy entrepreneurs” – individuals who have a vested interest in a policy’s success – to advocate policy placement on an agenda.⁸⁵ Successful initiatives are thus the product of both “coupling” and an “open window”; failed or ineffective attempts at agenda-setting result from a lack of “coupling” or “closed policy windows.” Research attempts to identify factors that engender each scenario within the rural health care policy arena: productive policy formation processes that feature coupling and an open policy window, and unsuccessful legislation that stems from failed coupling, closed windows, or a combination of both factors.

Case Studies

Case studies – specifically, a most similar systems case study design – are the most relevant methodology for this type of analysis. The academic literature informing social science methodology suggests that case studies are useful when identifying general causality. George and Bennett argue that these units of research “examine the operation of causal mechanisms.”⁸⁶ Robert Yin asserts that the research questions most frequently associated with case studies “deal with operational links needing to be traced over time.”⁸⁷ This study attempts to identify the factors that engender successful and ineffective rural health care initiatives – disparate phenomena that have occurred over the last four decades – and is thus consistent with the academic rationale for case study designs. Case studies are also applicable because the existing

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Kingdon, *Agendas*, 204.

⁸⁶ George, Alexander L., and Andrew Bennett., *Case Studies and Theory Development in the Social Sciences*, (Cambridge, Mass.: MIT Press, 2005); 19.

⁸⁷ Yin, Robert K., *Case Study Research: Design and Methods*, 2nd ed. Vol. 5. (London: SAGE Publications, 1994); 9.

academic literature avoids identifying causation and variables; Bennett and George argue that case studies comprise the primary tier of analysis and must be employed before other methodologies.⁸⁸ This study attempts to contribute to the rural health care conversation by identifying causation and variables. It utilizes a specific case study methodology: the most similar systems design.

Alexander George and Andrew Bennett explain that this design allows researchers to analyze the disparate factors – in largely similar cases – that yield different results. This methodology, they argue, is appropriate for studies in which one tries to divine the reasons for distinct results; one holds a majority of known factors constant while analyzing disparate, contributing elements.⁸⁹ A most-different systems design – in which one attempts to determine why disparate factors produce similar outcomes – is not relevant to this study because it fails to provide a comparison between successful and failed legislative initiatives; this type of design produces an understanding of similar outcomes engendered by disparate forces. A single case study is also ineffective in the context of this thesis: single case studies serve to dispel specific theories or establish a nuanced understanding of a policy, but they may be ineffective in firmly establishing general causality.⁹⁰

Research centered around two rural health care legislative initiatives: the Emergency Health Personnel Act (EHPA) of 1970 and the Health Care Access and Rural Equity (H-CARE) Act of 2007. The former represents a successful legislative effort: the EHPA was enacted by significant majorities in both Houses of Congress, signed by President Richard Nixon in 1970, and praised by *The New York Times* as landmark health care reform. The H-CARE Act represents a negative example; it was introduced into the House of Representatives by the bipartisan Rural

⁸⁸ George and Bennett, *Case Studies*, 21.

⁸⁹ George and Bennett, *Case Studies*, 22.

⁹⁰ George and Bennett, *Case Studies*, 23.

Health Care Coalition in 2007 and failed to pass through the House Finance Committee.

Numerous similarities are evident between these bills: each attempted to address rural health care disparities; both bills were enacted by a Congress that contained Democratic majorities in both houses; Republican administrations that had previously presided over moderate increases in federal health care spending – President Richard Nixon expanded the Medicare and Medicaid programs established by his predecessor, Lyndon Johnson, and President George W. Bush approved a comprehensive Medicare prescription drug program in 2003 – supported rural health care reform; and both bills argued that rural health care deficiencies were the result of economic market failure – they sought to correct this inefficiency. Similar legislative initiatives, however, produced disparate results. EHPA and H-CARE legislation were chosen because of their similarities. In addition, the EHPA was chosen because it represents the only major rural health care legislation – hailed as effective policy – enacted by Congress over the last four decades.

Information was obtained through interviews with rural health care scholars, an analysis of the Congressional Record, and an examination of articles in *The New York Times*. Several policy experts from the Oregon Health and Sciences University – employed at the Office of Rural Health Policy or Area Health Education Center – provided a nuanced understanding of the rural health care reform; Robert Duehmig and Dr. Lisa Dodson served as nonpartisan, primary sources. These interviews were supplemented with information from the Congressional Record; arguments and statements made by various congressmen and senators conferred a greater understanding of the EHPA and H-CARE Act. Articles and editorials from *The New York Times* provided information from media and popular opinion viewpoints. Together, these diverse sources allowed for data triangulation – they engendered a balanced understanding of rural health care policy initiatives.

Rural Health Care Policy Initiatives: Findings

Interviews, an analysis of pertinent newspaper articles, and an examination of rural health care legislative language suggest that elements of all three policy streams are responsible for inertia. Some streams are more influential than others; for example, the results of this study demonstrate that the political stream is more influential than the policy or problem streams: strong political leaders – in the executive and legislative branches – may override or overcome factors inhibiting legislative consideration and enactment. However, each stream plays an important role in policy formation and agenda-setting. Research indicates that a complex network of factors often influences rural health care legislation. The following examines each case study – the Emergency Health Personnel Act of 1970, and the Health Care Access and Rural Equity Act of 2007 – and the relevant policy streams.

The Political Stream

During the late 1960's and 1970's, the national political environment favored passage of rural health care legislation. Federal Medicare and Medicaid programs – enacted in 1964 as part of President Lyndon Johnson's War on Poverty – provided insurance to millions of previously uninsured Americans. This created a significant influx of new health care consumers.⁹¹ Legislators acknowledged the need for improved health care services, and the general public echoed these sentiments; several editorials published during this period convey a national anxiety regarding poor access-to-care.⁹² These factors created political conditions conducive to rural health care reform; they engendered a favorable "national mood."

⁹¹ Lyons, Richard D, "Doctors: To Get Them to Where They Are Needed Most," *The New York Times*, 17 January 1971, sec. E, p. 3.

⁹² Lyons, "Needed Most," E3; Schwartz, Harry, "Doctors Where There Were None," *The New York Times*, 28 May 1972, sec. E, p. 6.

Interviews with scholars suggest that initiatives were also aided by a strong and attentive executive branch. (President Nixon identified expanded health care coverage – to both rural and urban areas – as a national priority in 1971; while addressing Congress in 1971, Nixon asserted that “we must do all we can to remove any racial, economic, social, or geographic barriers which now prevent any of our citizens from obtaining adequate health protection.”⁹³ He later proposed several programs intended to address this problem – including the Emergency Health care Personnel Act. A sympathetic Congress – one that featured Democratic majorities in both the House of Representatives and the Senate⁹⁴ – passed the EHPA by an overwhelming majority: 343-22 in the House, and 77-16 in the Senate.

Newspaper excerpts suggest that the legislative branch, executive branch, and general public played equally important roles in affecting enactment. These elements of the political stream informed each other: the national mood influenced the Congressional and Presidential agenda;⁹⁵ cooperative legislators preached the importance of improved coverage to their constituents and the executive branch;⁹⁶ and President Nixon provided strong leadership, suggested policy alternatives, and articulated a clear philosophy to the legislative branch and public.⁹⁷ However, scholars argue that a strong and informed federal executive branch – one that identifies rural health care reform as a priority – is the most important contributor to successful rural health care legislation.⁹⁸ They assert that a presidential push for rural health care reform will overcome all other obstacles – in the political, policy, or problem streams – to legislative

⁹³ “Excerpts From the President's Message Urging 'a New National Health Strategy,'” *The New York Times*, 19 February 1971, sec. A, p. 16.

⁹⁴ Lyons, “Needed Most,” E3.

⁹⁵ Lyons, Richard D. “Medicare-Medicaid Funds Rise, But New Programs Seem Vague.” *The New York Times*, 30 January 1971, sec. A, p. 11.

⁹⁶ Lyons, “Seem Vague,” A11.

⁹⁷ Robert Duehmig (Communications Director, Oregon Health and Sciences University Office of Rural Health), in discussion with the author, October 2010.

⁹⁸ Duehmig, October, 2010; Lisa Dodson (Director, Oregon Area Health Education Center, Oregon Health and Sciences University), in discussion with the author, December 2010.

success.⁹⁹ This suggests that the political stream – within the rural health care policy universe – is the most influential component of policy formation.

In contrast, the political mood in 2007 did not favor rural health care policy enactment. Although a majority of Americans favored universal health care legislation, Congress and the Bush Administration focused on decreasing the size and scope of federal health care programs. Robert Duehmig, a rural health care scholar at the Oregon Health and Sciences University Office of Rural Health explains that rural health care programs “zeroed out”¹⁰⁰ under the Bush administration, and that Congress continually passed legislation restricting funding for programs like the National Health Service Corps.¹⁰¹ Duehmig argues that the Bush administration did not establish rural health care legislation as a priority;¹⁰² he asserts that funding for rural health care programs is a “drop in the bucket,”¹⁰³ – and that Congress passed numerous bills that increased the national debt – but the executive branch believed that rural health care programs were an “unnecessary expenditure.” This attitude contrasts sharply with that of the Nixon administration: Nixon established rural health care as a priority; President Nixon identified health care initiatives – for underserved communities – as a means of addressing national poverty. Several years after President Johnson’s “War on Poverty,” Nixon urged Congress to combat the “diseases of poverty.” Arguments made – during debate – by various congressmen reflect this idea. Senator Henry M. Jackson (D-WA) urged Congress to adopt the EHPA: “even in our relatively affluent State, we have seen vast areas with little or no health services available, and we have seen hundreds of our constituents wracked by malnutrition and the diseases of poverty.”¹⁰⁴

⁹⁹ Duehmig, October 2010; Dodson, December 2010.

¹⁰⁰ Duehmig, October 2010; Dodson, December 2010.

¹⁰¹ Duehmig, October 2010.

¹⁰² Duehmig, October 2010.

¹⁰³ Duehmig, October 2010.

¹⁰⁴ US Congress. Emergency Health Personnel Act. H.J. Res. 19246. S. Con. Res. 4106. 91st Congress. Washington, D.C. 21 September 1970.”

Congressional partisanship also contributed to legislative inertia. Duehmig and Dodson explain that a bipartisan and cooperative Congress willingly enacted the EHPA in 1970; a general bipartisan consensus regarding the need for additional services engendered immense Congressional support.¹⁰⁵ However, over the last decade, the House and Senate have become partisan bodies; more barriers to inter-partisan cooperation exist¹⁰⁶. Rural health care debates are often tied to larger, ideological arguments, and these discussions prevent bipartisanship. (These conversations are detailed in the “policy stream” section of this study) Scholars thus differentiate between widely-held, bipartisan beliefs, and bipartisan legislative efforts.

New Federalism rarely influences the political stream. Although the academic literature identifies New Federalism as the dominant political framework, newspaper articles and interviews suggest that political actors are more important than ideologies.¹⁰⁷ In 1970, President Nixon and a bipartisan Congress engendered rural health care reform; in 2007, a reluctant and adversarial Bush Administration and divided Congress failed to enact rural health care legislation. Ideologies inform political attitudes – including those driving partisanship – but research suggests that executive prioritization is the primary factor influencing rural health care initiatives.

The Problem Stream

The American public and media identified rural health care deficiencies as a “problem” in the late 1960’s and 1970’s, and they believed that these shortages constituted a “condition” in 2007. A *New York Times* Historical database search for “rural health care” returned numerous results during a period beginning in 1971 and ending in 1979; comparable numbers of articles

¹⁰⁵ Duehmig, October 2010.

¹⁰⁶ Duehmig, October 2010.

¹⁰⁷ Lyons, “Seem Vague,” A11.

are unavailable during any other period. (Small surges in articles relating to this subject occur when Congress considers universal health care legislation – most notably, around 1994 – but publication peaked between 1971 and 1979.) The absence of articles published around 2007 suggests that the media and public were not focused on rural health care disparities. Similarly, a search for “Emergency Health Personnel Act” produces six results; searches for “Health Care Access and Rural Equity Act” and “H-CARE” yield no matches. Interviews with rural health care scholars produce similar data: the public viewed rural health care deficiencies as a “problem” in the late 1960’s and 1970’s because newly-insured Medicare and Medicaid patients demanded improved medical services; in 2007, the country did not identify rural health care as a “problem” because of a lack of focusing events and immediate problems. Duehmig also argues that urban-centrism prevents health care disparities from becoming a “problem.”¹⁰⁸

Urban-centrism contributes to legislative inertia. This collection of beliefs regarding the exaggerated vitality of rural America, and the importance of agriculture to rural communities, negatively influences legislation. Duehmig characterizes urban-centrism as a “simplicity that people buy into about rural communities”¹⁰⁹ and explains that a “huge number of legislators involved (in the policy process) are urban-centric.”¹¹⁰ He argues that a significant majority of current committee chairmen – in both the House and Senate – come from primarily urban or suburban states or districts.¹¹¹ These legislators, he asserts, do not understand rural problems: they are informed by a belief in the overall health of rural people, and influenced by a powerful agribusiness lobby. Dodson echoes these concerns and also emphasizes the importance of informed Congressional leaders: “I think we get a focus on rural health issues when a

¹⁰⁸ Duehmig, October 2010.

¹⁰⁹ Duehmig, October 2010.

¹¹⁰ Duehmig, October 2010.

¹¹¹ Duehmig, October 2010.

knowledgeable legislator arrives at a position in their party and in their committee structure that allows them to have a bully pulpit.”¹¹² Most rural issues lack lobbies or effective lobbies; although rural economies no longer revolve around agriculture, this lobby dominates rural policy discussions because other prominent advocates do not exist. As a result, poorly-informed legislators believe that “once they’ve voted for a farm bill, they’re done voting for rural legislation.”¹¹³ This modern dearth of informed leaders contrasts with the prominence of rural legislators during the early 1970s; numerous committee chairmen argued – on the floor of the House and Senate – for the EHPA and cited the needs of their rural constituencies.¹¹⁴

A lack of rural health care crises and focusing events also contribute to legislative inertia. Without these experiences, legislators and the general public are less likely to view rural health disparities as urgent problems. Dodson alludes to this absence: “I think a sense of urgency comes out of a crisis and drives behavior. When we get something like a rash of rural hospital failures, then representatives start to pay attention. Constituents are saying: ‘our hospitals are failing.’ Rural health care tends to be very crisis driven.”¹¹⁵ This suggests that a lack of prominent focusing events has negatively impacted rural health care legislative initiatives – contemporary rural health care disparities remain an “issue,” rather than a “problem.”

Effective political leaders – an open political window – can overcome urban-centrism. Interviewees suggested that executive prioritization can overcome these biases. Duehmig explained that a “good, strong leader can cut through urban-centrism.”¹¹⁶ This leader must have a comprehensive understanding of rural health care deficiencies and establish rural health care

¹¹² Dodson, December 2010

¹¹³ Duehmig, October 2010.

¹¹⁴ US Congress, Emergency Health Personnel Act , H.J. Res. 19246, S. Con. Res. 4106, 91st Congress, Washington, D.C. 21 September 1970.”

¹¹⁵ Dodson, December 2010.

¹¹⁶ Duehmig, October 2010.

policies as a priority. President Richard Nixon exemplified these qualities; Nixon convinced urban-centric lawmakers to consider and enact effective rural health care legislation.

The Policy Stream

A coherent policy stream contributes to enactment. Several editorials from *The New York Times* – written during the early 1970’s – propose similar solutions: a comprehensive program that lures physicians to rural areas, or provides incentives to rural practitioners;¹¹⁷ federally-funded rural clinics that provide sufficient infrastructural support;¹¹⁸ and health care programs geared toward helping specific groups – for example, Native Americans. President Nixon, in his speech to Congress in 1971, proposed similar solutions.¹¹⁹ Congress enacted the Emergency Health Personnel Act later that year. Competing policies were not proposed or considered; instead Congress and President Nixon focused on incentivizing rural practice and improving infrastructure. This created a coherent policy stream, and interviewees attribute to the dearth of rural health care programs available during the 1970’s; Congress needed to address glaring rural health care deficiencies, and these policy proposals were simple and accepted solutions.¹²⁰ These programs were consensus starting points. During legislative debate, several senators framed the EHPA as an experimental legislative forerunner; Senator Ralph Yarborough (D-TX) characterized the Emergency Health Personnel Act as an “experimental approach to the problems of health care delivery in physician-deficient areas.”¹²¹

In contrast, a complex and incoherent policy stream characterizes the modern rural health care debate. Legislators and policy experts espouse divergent theories of reform: some

¹¹⁷ Lyons, “Needed Most,” E3.

¹¹⁸ Hicks, Nancy, “S. I. Poverty Area Getting Federal Medical Help,” *The New York Times*, 3 June 1972, sec. A, p. 22.

¹¹⁹ Lyons “Seem Vague,” A11.

¹²⁰ Duehmig, October 2010.

¹²¹ US Congress, Emergency Health Personnel Act, H.J. Res. 19246, S. Con. Res. 4106, 91st Congress, Washington, D.C. 21 September 1970.”

individuals believe that Congress should focus on addressing market failure, while others believe that the federal government should improve rural dynamics - it should emphasize comprehensive reform.¹²² Dodson suggests that some scholars focus primarily on financial incentives; other policy experts propose a system in which the federal provides adequate health care support services, educational opportunities, and financial incentives for rural physicians.¹²³ This leads to a jumbled policy stream. Lawmakers also debate the larger political ideologies that inform policy proposals. These policies are often tied to larger issues: for example, the role of the federal government and private companies in delivering health care, the federal tax structure, and issue prioritization. Duehmig points to the H-CARE Act as an example of partisanship and political fighting. H-CARE, in part, creates incentives for rural practitioners by adjusting Medicare reimbursement rates; under this legislation, rural physicians would enjoy greater reimbursement rates.¹²⁴ However, the tax policy would also need to change, and Congressional Democrats argue against tax reform.¹²⁵ This bill is thus tied to larger, more complex political debates. As a result, lawmakers who favor rural health care reform – especially members of the Democratic Caucus – rejected the H-CARE Act. These factors combine to produce an incoherent policy stream.

Conclusion

Research suggests that a combination of factors promote or inhibit rural health care legislation. Kingdon's three streams – the political, problem, and policy streams – each play prominent roles in the rural health care policy zeitgeist, although some streams are more influential than others. The national political environment, legislative branch composition, and executive branch prioritization comprise the political stream; urban-centrism, the agribusiness

¹²² Duehmig, October 2010.

¹²³ Dodson, December 2010.

¹²⁴ Duehmig, October 2010.

¹²⁵ Duehmig, October 2010.

lobby, and focusing events affect the problem stream; and coherent or incoherent policies often characterize the policy stream. A favorable national political environment, prominent and informed congressmen, and a strong executive branch contribute to rural health care policy enactment; dyspeptic public opinion, an absence of rural legislators, and an unsympathetic presidential administration engender legislative failure. Urban-centrism and the agribusiness lobby consistently impact rural health care legislation; however, research indicates that these factors may be overcome by an effective executive branch – for example, the Nixon administration in 1970. This suggests that the political stream, within the rural health care policy arena, is the most influential factor impacting legislative initiatives. Coherent policies encourage legislative success; incoherent and competing policies engender inertia.

Both Duehmig and Dodson suggested that the contemporary lethargy surrounding rural health care legislation may end during the next congressional session.¹²⁶ The Obama administration significantly increased funding for rural health care projects – including the National Health Service Corps; this signals executive branch willingness to improve rural systems. In addition, recent universal health care legislation enacted by the 111th Congress and signed by President Obama will create a large population of individuals requiring health care services; these newly-created health care patients will likely seek, and demand, improved access to quality care.¹²⁷ This rural health care renaissance may alleviate basic health care demands throughout rural America and ensure that M. Denise Williams and Margaret Hobson can focus on practicing medicine – and not moonlighting as matchmakers.

¹²⁶ Duehmig, October 2010; Dodson, December 2010.

¹²⁷ Dodson, December 2010.

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